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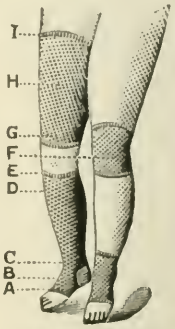

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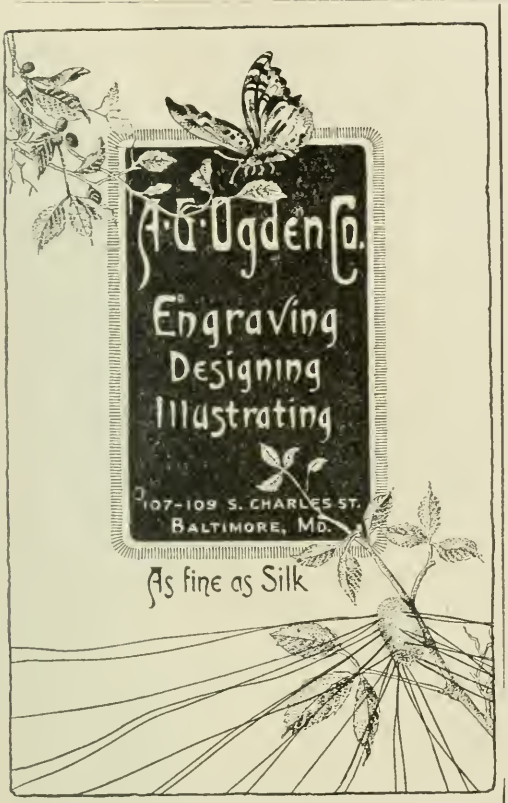

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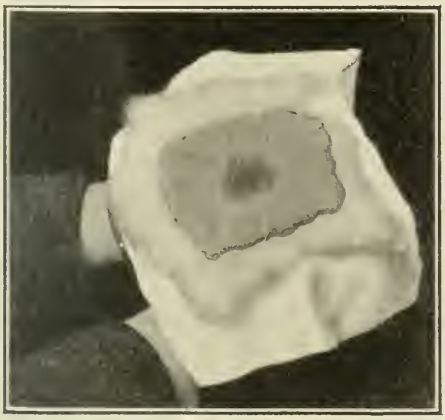

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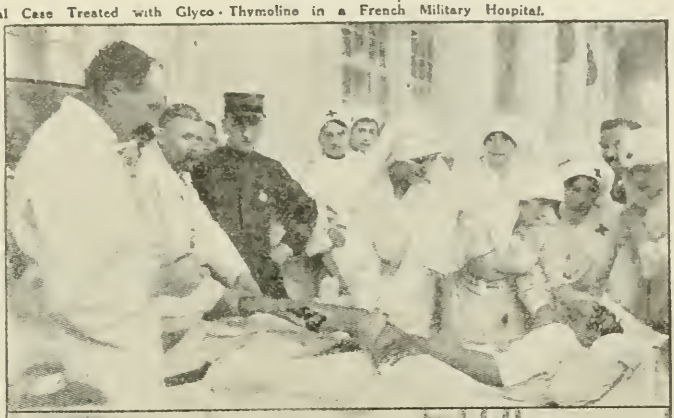

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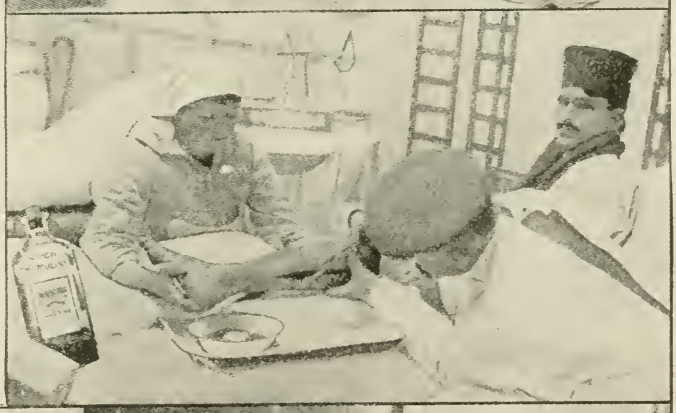

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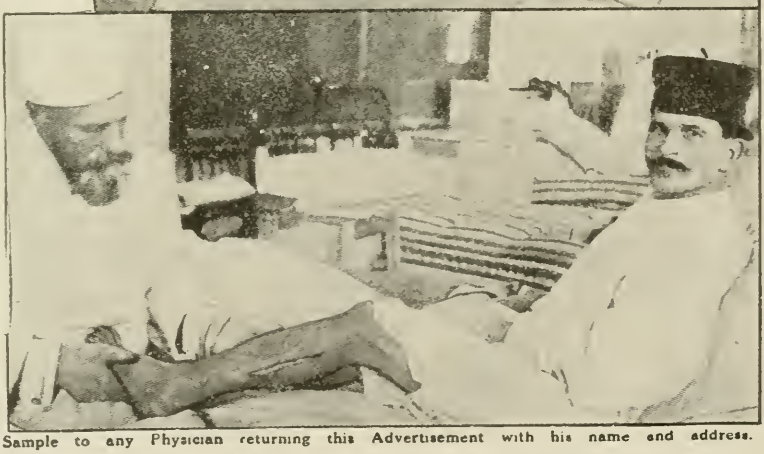

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CÆSAREAN SECTION—INDICATIONS AND TECHNIQUE AS PERFORMED BY THE AUTHOR.*

Erasmus H. Kloman, Ph.G., M.D.,
Baltimore, Md.

When one carefully studies the literature published on obstetrical problems since the advent of aseptic surgery, two important advances seem to stand out as milestones. One is an advance in obstetrical therapeutics. The animal drug, extracted from the posterior lobe of the pituitary gland, has so lessened the apparent and real necessity for obstetrical forceps that we should all welcome it with a prayer of thanks. The other milestone is the one I have selected to talk on to you today, the modern Cæsarean Section. I say "modern" because, as you know, this operation has been done for ages. It was used by the early Egyptians, who performed the operation after the death of the mother with the hope of saving the child. Again, in the sixteenth century, it was done on the living, the method being described by Porro in his method of amputating the uterus. Cæsarean Section has continued to progress along with other surgery, receiving its greatest stimulus with the advent of the principals of antisepsis and asepsis. From being an operation used as a last resort, and nearly always fatal, it has been gradually improved until now we hardly expect more than 3 to 5 per cent. mortality.

In the last few years it has become more and more popular as a method of delivery in cases where difficulty is expected or encountered. But, like every other new idea in medicine, being a grandstand performance, it is in danger of abuse.

With a limited time at my disposal, I want to try to give you the true indications for the operation and a short reference to the technique.

When I began to do Cæsarean Sections I was frequently embarrassed by the criticisms of my friends that "the child would have been born without such an operation," but their words soon failed to cut so keenly when I realized the same criticism could be passed

*Read before the annual meeting of the Medical and Chirurgical Faculty of Maryland, April, 1915.

upon men working in any branch of medicine or surgery. Yet the restraint of criticism is good, for I know the operation is done at times without proper thought and care—in such cases, for instance, as operation on a septic woman; operating to remove a retained head where the body has been pulled off by brute force, and opening the abdomen when the child is not known to be alive.

I would first like to group the indications for Cæsarean Section and then respectively outline them for your consideration.

First—We have obstructions to birth—contracted pelvis, pelvic tumors, carcinoma of cervix, undilatable cervix, ventral fixation of fundus and large child.

Second—We have immediate danger to mother or child—eclampsia, uterine hemorrhages, either placenta previa or premature separation of the placenta, funis presentation.

In cases of contracted pelvis where the conjugata vera measures seven and a half centimeters or less I think all of you will agree with me that the Cæsarean Section is indicated, providing surgical cleanliness and a living child exist. Again, when the deformity is so great that the true conjugata measures five and a half centimeters or less with the large child, whether dead or alive, Cæsarean Section is indicated, because we cannot safely do a destructive operation through a small outlet even after craniotomy. When we come to those pelves that give a conjugata vera larger than seven and a half centimeters it must be born in mind that measurements are not always infallible, and the accoucheur should take into consideration not only the conjugata vera alone, but, as Dr. Williams has so clearly shown us, the measurement of the pelvic outlet as well. The size and position of the child's head must also be considered. It is not an easy task to estimate the size of the child's head by Mueller's method, and to my mind the judgment of an experienced accoucheur is far more accurate. These cases every obstetrician should explain in advance to the parents, that, should difficulty arise, the abdomen may be opened with safety, provided examinations have not been made. The woman may select, if she so wishes, this operation before other uncertain and hazardous ones are tried. It is then the obstetrician's duty to equip himself with the art of external palpation during labor and to call upon expert assistance before he makes an internal examination or before the patient becomes exhausted.

Lastly comes a series of cases where a given woman has a slightly contracted pelvis, but has had several confinements with long labors, resulting in forceps deliveries of dead children. These women, to my mind, should be given a choice between Cæsarean Section or premature induction of labor, the latter of which is not without danger to the mother, does not by any means guarantee her a living child or one that will live even though born alive. However, even though the patient is a primpara and selects Cæsarean Section for a slightly contracted pelvis, I think she should be given a chance for natural delivery.

TUMORS OF THE PELVIS.

Fortunately, we do not see many cases with tumors of the pelvis, for most women with large myomata or ovarian tumors fail to conceive or abort early in their pregnancy. However, we do find these tumors in the passive part of the uterus obstructing the passage of the head. All such cases are more happily treated by Cæsarean and the tumor or tumors removed at the same time with the uterus. If these cases are diagnosed early in pregnancy, it is more practical, certainly so far as ovarian tumors are concerned, to remove them early. This does not necessitate Cæsarean Section, and only causes abortion in about 1 per cent. of the cases. When the pregnancy goes to full term a Porro operation is indicated. Cases of carcinoma of the cervix are, happily, rare, yet when they are met with, I feel sure you will agree with me that all advanced cases at least are better treated by this operation.

We know that most cases that have one of the many operations to correct retrodisplacements go through subsequent labors without difficulty, but occasionally we see cases where the fundus has become fixed and the cervix points toward the promontory of the sacrum. The child frequently presents abnormally, and should labor be allowed to progress, most of these cases would result in rupture of the uterus. Again, we see cases of atresia of the vagina, double vagina and atresia of the cervix due to scar tissue either from previous labors or, as I have seen, from very strong antiseptic douches. Is it not better here to do a clean abdominal operation rather than let the child's head tear its own canal? I believe that all these cases, including those where a large child is causing a very difficult labor, are better treated by clean, quick abdominal operation rather than trust that an operation from below will give you a living child. In the latter course lacerations and permanent harm done the mother is so great that if she does live she may be left a permanent invalid to remain sterile or have some dreaded fistula requiring large plastic operations for their correction.

Under conditions of immediate danger to mother or child we first have eclampsia. Believing that I am not assuming when I say that the majority of obstetricians agree to empty the uterus early when eclampsia exists, then we must do the operation of least danger to the mother and child. All cases where the disease appears before labor and before the cervix is dilated, where the child is viable or where there is slight pelvic disproportion, are best treated by abdominal Cæsarean. Vaginal Cæsarean is only indicated where the mother is septic or the child under seven months. In cases where dilatation can be easily completed by the manual method, delivery from below is better treatment.

PLACENTA PREVIA.

I, personally, am inclined to think that all cases diagnosed early, whether partial or complete, are best treated by Cæsarean, provided the case has not been handled much and dilatation is not

complete. It certainly stands to reason that waiting to do a version or some other operation is more dangerous for the mother, and we know that foetal mortality is very high in this disease. In all cases of complete placenta previa at or near term Cæsarean Section is the operation of choice. In concealed hemorrhages due to premature separation of the placenta we are seldom so fortunate as to find the child alive. The uterus is generally very rigid with no dilatation and the mother showing great shock, as in ectopic gestation. Here is one case in which I believe any good man is justified in doing a Cæsarean Section in a private home, provided he is equipped to control hemorrhage and use fair technique. By quick work he may save both patients. Even if there is a question of the child's being dead, I believe we are justified in doing an abdominal operation to save the life of the mother, the vaginal route being much slower and not so certain. I have never seen a case of the so-called funis presentation, but should I encounter this condition ,and should it persist, I should immediately advise Cæsarean Section.

Before taking up my technique for Cæsarean Section I would like to ask for a few moments to consider the contra-indications for Cæsarean and to give a few words about Pubiotomy, which is the operation most likely to come in competition. First, Cæsareans are rarely ever indicated where the mother is septic, where many internal examinations have been made, where the foetus is dead or where some deformity such as Hydrocephalus is known to exist; second, where the condition indicating its use appears before viability of the child and where the operator is not competent and good technique cannot be used.

I feel duty bound to say just a word about Pubiotomy, because I am not in favor of this operation except in rare cases and then only in the hands of very skillful operators. In the first place, it requires at least two more assistants. Danger of uncontrollable hemorrhage is great, rupture of the bladder is not unheard of, and you do not have the same guarantee that you will deliver the woman. Tears are common, and, to my mind, there is quite as much danger of infection; the puerperium is longer and the result more uncertain. The one argument in its favor is that you may get a larger pelvis with the next labor, requiring no operation.

TECHNIQUE.

In all cases except where sepsis is highly probable and those cases where I expect to remove the uterus I have practiced the following technique: After the external vagina is thoroughly shaved and cleaned with soap and water, followed by bichloride solution, I have a large, hot, salt vaginal douche given. Then the patient is catheterized and the vagina swabbed out with 70 per cent. alcohol followed by iodine. The abdomen is then shaved and cleaned in the same way, or, if the particular hospital uses iodine alone, I see no reason to object to its method.

The abdominal incision, about six inches long, is made a little to

right of midline, high up, two-thirds of it being above the umbilicus. Hot towels are then placed so as to cover the edge of the abdominal wall, and the assistant then pushes the uterus to the right side so the incision can be made low down and to the left of the midline of the uterus. This is done to avoid contact of the abdominal and uterus scar and to lessen possibility of adhesions. Before incising the uterus several large gauze packs are arranged to prevent Amniotic fluid coming in contact with the peritoneum. I think there is less contamination in this method, when carefully done, than when the uterus is delivered and fluid allowed to run down its side. The uterus is not delivered before the child. If the placenta is on the anterior wall, it is torn through and one of the legs of the child grasped and delivered. This should be followed quickly by removal of the placenta and membranes by the assistant. I have learned by experience to make no attempt to control hemorrhage by placing bands or assistant's hands around the lower segment. This is practically of no importance compared with getting the uterus empty and massaging the fundus with firm pressure in hot towels at the same time as delivering the uterus through the abdominal incision. Never get frightened when placenta is on the anterior uterine wall. Quick delivery is what you want, and no attempt to clamp off uterine sinuses will do good. I always tell the assistant, who is holding the uterus in hot towels, that it is not an egg and he cannot hurt it by firm hand massage. Having the uterus emptied of all its contents, we then put in two layers of interrupted No. 2 catgut, using a third continuous suture to overlap the peritoneum so there is no raw area. If the uterus does not contract fully, it is well to give a hypodermic of pituitrin of ergot, but hot towels and massage usually suffice. The gauze is now removed. If sterilization is necessary it is done by resecting uterine ends of tube. I do not dilate the cervix, even though dilatation is slight, unless internal examinations have been made and it is necessary to drain. The abdominal wall is sutured in the usual way and the patient then treated as any other puerperal case.

In septic cases where likelihood of peritoneal soiling is evident there are many operations to choose from. I am in favor of doing the Porro operation or complete Panhysterectomy with thorough drainage. Of course, this is an operation none of us like to do, as here we remove from a young woman the organs which will not only make her sterile but will bring on a premature menopause with all its distressing symptoms. These are the cases where the operation has its weakest points, and I sincerely trust that some of the operations devised will prove themselves worthy in the future of a place in obstetrical surgery. Among these latter we have the extra-peritoneal route devised by the Germans and done in this country by some few men. Kerr pushes the placenta and membranes through the cervix after removing the child. Sellheim formed a utero-abdominal fistula at the lower part of the abdominal wound to shut off the peritoneum from infection.

To the general surgeon who may do this operation, without the

previous bitter experience and hard work of the obstetrician, I would like to say that this operation is no clean appendix, no gastro-enterostomy, but a work fraught with special danger of infection, as are all operations on pregnant women.

ANESTHETIC.

I think a great deal could be said on the choice of the anesthetic to be used. In the past three years I have been using a method suggested by Dr. S. W. Moore and Dr. S. Griffith Davis, and it has given excellent results in the hands of these two men, who have shown much interest and assisted me materially. Chloroform is not a good anesthetic in obstetrical work if you have a long operation, as it is not an uncommon thing to have chloroform poisoning result in a few days following, or even death from failure of the heart at the time. Ether is not as well borne by the child as chloroform and it is frequently necessary to do much resuscitating after delivery of the child. We, therefore, decided to compromise and begin the anesthetic with chloroform until delivery was complete, which only takes a few minutes, then to switch to ether and complete the operation. With this anesthetic I have had no cynotic births; in fact, I have been able to make nearly every delivery with the child crying lustily when it was handed to the assistant.

Just a word in conclusion to give you a brief idea of my own cases. I have now done 30 of these operations, and the indications cover nearly all that I have spoken of in this paper. My results have been very happy, only one death of a mother and that due to infection. Every child has lived. Three of my cases were done in private homes, one in eclampsia 48 hours. Two of the operations were for complete placenta previa, six for eclampsia, one for fibroid in cervix, one for ventral fixation with a transverse presentation, eleven for absolute indications, eight for slight indications. Among these one Cæsarean was done on a woman weighing 300 pounds, who had had four pregnancies with no living children. Child and mother are both well. One case I did the third Cæsarean on for absolute indications. I sterilized her, as I felt she has done her part.

For the foregoing reasons, you see, I have a great deal of respect and regard for this operation, and I believe it to be a good operation when properly selected. It is one that will not only take away the horrors of badly contracted pelves, but will aid materially in placenta previas, eclampsias, pelvic tumors, and last, but not least, those border-line cases and high-forceps cases where the mother will be allowed to have a say and lessen for herself those dreaded conditions following brutal and uncertain results of the obstetric forceps. It has the added virtue of making certain your delivery, lessening the chance of hemorrhage and relieving suffering.

Remember that it is not alone the function of the obstetrician to so improve his art that the maternal mortality will be lowered, but to give the foetal mortality a consideration of close second.

1800 N. Charles St.

MULTIPLE VENEREAL COMPLICATIONS—REPORT OF CASE.

Sylvan H. Likes, M.D., and Herbert Schoenrich, M.D.,
Baltimore, Md.

It is not at all unusual to see more than one venereal disease affecting an individual at one time. We often have patients, after presenting an acute gonorrhea, develop a few days subsequently an initial lesion of syphilis, and occasionally thereafter gonorrheal complications.

The report of this case is of interest, not only on account of the number of complications existing at one time, but the peculiar mental attitude of the patient regarding his afflictions. Mr. M., age 32, recently presented himself for treatment. Examination revealed six sores on his penis—one, fairly large, involving the frenum, ulcerating in character, considerably infected and slightly resembling a soft chancre; another, dime size, edges very slightly indurated, in the region of the center of the penis. None of these sores were much indurated, and clinically it was impossible to make a positive diagnosis. These sores were covered with a foul, grayish exudate, and from the fact that there was such slight induration, and, furthermore, that several examinations of the secretion under the Dark Field Condenser failed to reveal any evidence of the treponema pallida, led us to believe that these sores were soft chancres rather than multiple initial lesions. The fact, however, that later the Wassermann showed a triple positive reaction and the lesions responded promptly to anti-syphilitic medication forced us to change this tentative diagnosis from soft chancre to multiple hard chancres. While it is possible that these sores on the penis may have been manifestations of a previously existing lues, the absence of any other lesions or history thereof, as well as the marked inguinal adenitis, led us to exclude such a possibility. We may add here that the failure to find spirochaetes in sores which later investigations prove to be initial lesions is contrary to our findings and stamp this as a marked exception to our experience. The prepuse was edematous and inflamed to such an extent almost producing a phimosis. The entire organ was swollen and sensitive. The inguinal glands on both sides were swollen; those on the right side were on the verge of suppuration. Furthermore, he had a gonorrhea which dated back several weeks, and we found that not only was his anterior urethra affected, but also that the prostate and bladder were involved. The urine was very purulant, and the three-glass test showed a uniformly cloudy urine. The prostate was enlarged and tender, pus rich in gonococci exuding on massage. He was extremely irregular with his visits, and within 10 days after his initial visit developed an epididymitis, complaining at the same time of severe pain in his perineum and rectum. This pain was due to a gonorrheal periurethral abscess pointing toward the perineum and to a large protruding hemor-

rhoid. And last, but not least, he was not forsaken by the pediculosis pubis that surely felt an equal right to be present as a delegate to represent the animal parasites. Strange as it may seem, the pain from the hemorrhoid apparently caused him more consternation than all of his other complaints combined. Thus the complete diagnosis: Multiple chancre, constitutional spyhilis, gonorrheal urethritis, gonorrheal prostatitis, gonorrheal cystitis, gonorrheal periurethral abscess, epididymitis, hemorrhoids, pediculosis pubis.

By the time when the complete diagnosis was fully established the patient, a painter by trade, unable to obtain employment in Baltimore, had to go elsewhere to seek work.

After this brief description of the physical aspect of this much venereally afflicted individual, a word of his mental attitude toward his condition adds to the interest of this case, for when we informed him that the Wassermann test of the blood serum was strongly positive and that he was thus affected with constitutional syphilis, we thought it not amiss to lend a little cheer to the series of glooms by saying that we hoped he would not let this extra added feature worry him. He nonchalantly answered: "Nope; there is no use worrying about that, just so the pain from my piles go away!"

REPORT OF TWO CASES OF SARCOMA OF THE SCAPULA.

By Randolph Winslow, M.D.

On September 8, 1898, R. F., an Italian woman aged 21 years, and married, was admitted to University Hospital. As she spoke no English, it was impossible to obtain any adequate history of her case. Physical inspection soon determined that she was several months advanced in pregnancy. She was thin and anemic in appearance. The condition for which she sought relief was a large growth involving the left scapula, and which had grown rapidly. This tumor projected on the dorsal surface of the body as a rounded mass almost the size of an infant's head. It was solid, but not very hard, and was judged to be a sarcoma of the body of the scapula. There was also involvement of the axillary glands. With much difficulty permission was obtained to remove the tumor, but an amputation at the shoulder was prohibited. We were, therefore, handicapped from the start; nevertheless I attempted the extirpation of the growth, with the preservation of the arm. The patient was not a good subject for operation.

A cross incision was made over the scapula, and the bone separated from its connection with the thorax, but the glenoid cavity, coracoid process and a portion of the acromion were not removed; that is, the neck of the scapula and acromion were sawed through. An attempt was made to clean out the axilla, but it could not be

Fig. I.—Sarcoma of scapula.

Fig. II.—Sarcoma of scapula excised January, 1915. Before excision.

Fig. III.—Excision of scapula for sarcoma.

done satisfactorily. The woman was considerably shocked, but rallied, and made a good recovery from the operation, and left the hospital in less than a month with her wounds healed. She gave birth to a child at term, but died of recurrence within a year.

Case II. Jessie J., a colored girl 20 years of age, and married, was admitted to University Hospital on January 14, 1915. Her complaint was a lump on the back involving the right scapula. This began as a small lump two years ago; but before she noticed any swelling there had been some pain in the right arm and shoulder. She had had a fall, but does not know that she struck her back. When discovered the growth was about the size of a hickory nut, but it gradually increased in size and became painful, the pain and soreness extending in various directions. The pain begins about 4 o'clock, and continues all night, seriously interfering with her sleep. She has lost 15 pounds in weight during the year, and is in rather poor condition. On inspection a rounded mass about the size of a closed fist is seen over the right scapula. This is solid, and moves with the scapula. No glandular enlargement was felt, and there was no involvement of the tissues around the right shoulder.

A diagnosis of sarcoma of the scapula was made, and an extirpation of the scapula was recommended and accepted.

Operation was done on January 18, 1915. A straight incision was made along the posterior border of the scapula, and another along the spine and acromion process. The muscles connecting the shoulder blade with the trunk were severed, and the deltoid detached from the spine. There was rather free bleeding before the vessels could be secured. When the parts had been sufficiently exposed the acromion process was sawed through at its junction with the spine, and then the neck of the scapula was divided with a small saw. In this manner the coracoid process and the glenoid cavity, as well as a portion of the attachment of the deltoid muscle, was preserved. The wounds were sutured without drainage. She was badly shocked, but an intravenous infusion of salt solution caused a rapid improvement in her condition, and she progressed favorably. Following the shock her temperature reached 102⅘, pulse 150, soon becoming nearly normal. She was discharged on February 16, 1915. I saw her about six months subsequently, and found a very normal-looking shoulder, but with little active movement at the shoulder joint. The function of the elbow joint and forearm were well performed. She was complaining of pain in the front of the chest, and there seemed to be a thickening of the tissues over the sternum. I imagine, therefore, that she has a recurrence at this point. I advised her to return to the hospital, but she failed to do so, and I have not seen her since.

Sarcoma of the scapula appears to be a comparatively rare disease, and in most of the textbooks in my possession it is not mentioned at all. When it is well developed there is little difficulty in recognizing the condition, but by this time metastases have usually

occurred, and the opportune time for operating has passed. When it is thought proper to attempt the eradication of the disease, the removal of the whole scapula should be done, with, perhaps, the exception of the glenoid cavity, coracoid process and acromion. It is not only a less difficult matter, but a less serious one to leave these structures in situ, and it leaves a more useful joint than would be the case if these parts were removed. The operation is a serious one, and there is usually considerable loss of blood. The vessels should be exposed and tied in continuity before being cut. Joseph D. Bryant says that 66 complete excisions of the scapula have been done, with 14 deaths, or nearly 22 per cent.

A SIMPLE METHOD OF REMOVING FLAT FOREIGN BODIES FROM THE TRACHEA OF THE YOUNG CHILD.

By Richard H. Johnston, M.D.,

Baltimore, Md.

THE method to be described is designed for the rapid removal of flat foreign bodies from the trachea of infants and children up to the age of three years. To the beginner no operation is more difficult than the removal of foreign bodies through the small bronchoscopes designed for infants. To the expert the operation is sometimes fraught with difficulty, because it is not easy to work through a 4 mm. tube unless the child is asleep, which adds to the danger of tracheoscopy. Flat foreign bodies, such as watermelon seed, seldom pass into the bronchus of an infant or young child. They lodge in the trachea almost invariably, and necessitate a tracheoscopy for removal. To obviate the difficulties of working through a small tube, I had a small Jackson separable speculum made which measures 9.5 cm. in length and 10 mm. in diameter, with the light 1 cm. from the end of the tube. With the handle detached the speculum is passed into the throat, with the child's head straight on the table. The epiglottis is pulled up, and, with the child breathing, the trachea can be explored to the bifurcation. A foreign body can be easily seen, and if it is light in weight, as a watermelon seed, it moves up and down with expiration and inspiration. Forceps, introduced between the vocal cords, are made to grasp the object, which is quickly removed. No anesthetic is used. Atropin is given to dry up secretions. In the removal of two watermelon seeds from the trachea of young children I was surprised at the excellent view of the entire trachea with the head straight on the table. I have no doubt that this method will work equally as well with foreign bodies or other shapes. Thus far I have had occasion to use it only with flat foreign bodies.

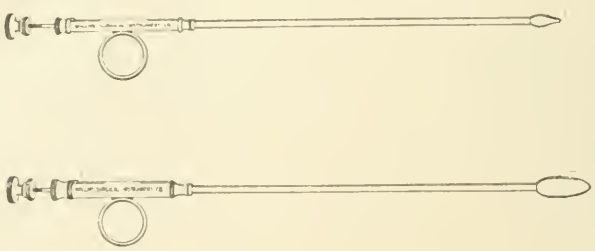
807 N. Charles street.

AN IMPROVED URETHRATOME.

By Page Edmunds, M.D., F.A.C.S.

An instrument devised for cutting so-called impassable strictures of the urethra without a guide. Also for complete incision of the cicatricial tissue without damage to the normal mucosa of the canal.

The set of Urethratomes consists of three instruments varying in size and construction. The first instrument to be used consists of a bulbous bougie, size 22 "F," with knife concealed in the bulb; when extended the knife projects one-eighth of an inch in advance of the point. In use, the point of the urethratome is engaged in the obstruction, the knife advanced, and the obstruction incised one-eighth of an inch. This procedure is repeated until the obstruction has been passed.



The second instrument is much like the ordinary bulbous bougie in shape, with a knife concealed in the bulb. When the knife is advanced, the cutting occurs only on the greater circumference of the bulb. The size of this instrument is 26 "F," which fills exactly the incision made by instrument No. 1.

The third instrument, which completes the set, is exactly similar, being 33 "F" in size and filling exactly the incision of No. 2.

On the handle of No. 2 and No. 3 urethratomes there is a stop which can be used to regulate the depth of the incision. No. 2 and No. 3 are used exactly as one uses olivary sounds to locate obstructions, and incision is then made at this point.

The advantages claimed for these instruments are: Incision of strictures of small caliber without a guide, and elimination of the possibility of false passage. The larger urethratomes completely incise the scar without causing further damage.

These instruments have been in use in the University Hospital by practically all of the surgical staff with very happy results.

A CASE OF INTERSCAPULO-THORACIC AMPUTATION OF THE UPPER EXTREMITY FOR SARCOMA OF THE SHOULDER.

By Nathan Winslow, A.M., M.D.,
Clinical Professor of Surgery, University of Maryland.

WHETHER a sarcoma of the bone ever follows a trauma sufficiently severe to produce facture is still a debatable question. Murphy asserts positively that sarcoma never follows, but always precedes, fracture, and in his writings declares that in his experience he has never seen a sarcoma following a trauma sufficiently severe to produce fracture. Such a sequence is true in the majority of cases, and possibly in every instance. The case about to be reported appeared at first glance to be an exception to this rule, but a closer examination of the first skiagram (Fig. 1) positively shows sarcoma. The interest in the case then centers in its agreeing with the dictum of Murphy, and in the fact that the patient now, more than two years after an interscapulo-thoracic amputation, is alive and in excellent health.

Case M. S., male, Finn, married, chair caner, aged 40, a resident of Baltimore, was admitted to the University Hospital, service of Prof. Randolph Winslow, June 7, 1913, suffering with a lump in the shoulder. As there is nothing of interest in the past or family history of the patient, this phase will be omitted. The present history dates back to November 4, 1912, when the patient entered the University Hospital with a fracture of the surgical neck of the humerus. The fracture was incurred by the patient falling down an open areaway several days preceding the injury while on the way from his room to his boarding-house. As the shoulder continued to bother him after using home remedies, he came to the hospital for examination. It was then that a fracture was suspected, a skiagraph ordered, and the diagnosis confirmed. He remained in the hospital until December 3, 1912, when he was discharged as cured, with the following discharge note: "Fracture is united, patient is able to move arm in all directions, and suffers no pain; there is no deformity." Undoubtedly, if one had been on his guard, he would have recognized in the first X-ray, as well as in another taken after the fracture had been reduced, a beginning sarcoma. However, the fact that the patient was suffering with a pathological fracture was overlooked, and as the shoulder, after a lapse of several months, began to swell and give pain, the patient returned to the hospital on June 7, 1913, for further advice. Upon examination the shoulder was found to be markedly swollen, and the upper end of the humerus distinctly enlarged. Sarcoma was suspected and a skiagraph ordered. The radiograph showed that our suspicions were correct. The patient was, therefore, advised to have a resection made of the shoulder

Fig. I.—X-ray taken when patient first entered hospital, upon which the diagnosis of fracture at surgical neck of humerus was made. A closer inspection would have shown beginning malignancy. (Taken with screen image reversed.)

Fig. II.—X-ray upon patient's second entrance to hospital, showing malignancy well developed.

Fig III.—Appearance of patient after amputation. Scar line is plainly visible.

and a bone implantation done. He consented, and on June 30 was taken to the operating-room and a resection begun, but the surrounding soft tissues were found so invaded that after ligating the axillary vessels an interscapulo-thoracic amputation was made. The post-operative course was smooth, and the patient left the hospital August 1, 1913, with the wound completely healed, and in excellent physical condition. He has been heard from only recently, and writes he is enjoying excellent health.

Of course, it is too soon to state that a permanent cure has been effected, but certainly two years of life in excellent condition is worth the risk taken in undergoing an operation of such magnitude. At operation the contiguous tissues were so involved that the operator did not expect to give the patient more than a month or two of life at most, so he is more than pleased with the present outcome. The lesson which we desire to drive home is that malignancy is of varying degrees of intensity, and that operation offers the only hope of prolonging life.

Book Reviews.

THEORY AND PRACTICE OF BLOODLETTING. By Heinrich Stern, M.D., LL.D., Visiting Physician, St. Mark's Hospital; Consulting Physician, Methodist Episcopal (Seney) Hospital; State Hospital at Central Islip; Deaconesses' Home; Port Chester and Glen Falls Hospitals; Founder and Editor of the Archives of Diagnosis; Formerly Chairman, Section on Pharmacology and Materia Medica, American Medical Association; President Manhattan Medical Society; Fellow of the American Urological Association, the American Therapeutic Society, the New York Academy of Medicine, etc. New York: Rebman Company. 1915. Cloth, $2.50 net.

Bloodletting, perhaps the oldest of man's remedies, now, after a period of more or less innocuous desuetude, is again beginning to claim attention, perhaps only to pass through one of its many cycles of popularity then to fall into disrepute. It is safe to say no other remedy has passed through so many vicissitudes. Now praised beyond merit, then unjustly condemned, venesection has retained its virility throughout the ages. It has risen, rejuvenated and with new vigor, from the ashes of the fire which threatened its destruction more than once. The people at large, undisturbed by academic strifes, have always been true to it. The physicians have extolled it to the skies or condemned it in the bitterest fashion in accordance with the prevailing status of scientific knowledge. Although we again resort to this remedy of our ancestors when occasion arises, we practice it with a clear and accurate understanding of its physiological, pathological and therapeutical rationale, while they made rather intuitive use of it, employing it in accordance with custom, without discrimination, and on fanciful

and fallacious suppositions. Undoubtedly with a clearer understanding of its principles and when and where it is proper to be employed, bloodletting will become more popular. The reviewer himself has used it with great satisfaction in those cases in which the lungs were filling up from a non-compensating heart. He finds a weak fluttering pulse no contraindication. These cases respond promptly, and from being in a most helpless and deplorable condition, anxious, face beaded with perspiration and gasping for breath, they pass miraculously into a condition of comparatively well-being. Stern has attempted to give a comprehensive and scientific monograph on when and where not to employ bloodletting. He realizes that in some instances it is a good agent to employ, and that it should be employed more generally than it is. Read his book and be converted, at least partly, to his views.

International Clinics. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Volume I. Twenty-fifth Series. 1915. Philadelphia and London: J. B. Lippincott Company. Cloth, $2.00.

This volume contains articles on many burning topics of the day, such as "Emetine in the Treatment of Emebic Dysentery," by William Allen, M.D.; "The Value of the X-ray Examination in the Diagnosis of Gastric Cancer," by James T. Casey, M.D.; "Epithelioma: Its Early Diagnosis and an Excellent Method of Treatment," by William H. Best, M.D.; "The Treatment of Malignant Tumors by Electrical Methods," by Arthur F. Holding, M.D.; "The Early Diagnosis of General Paresis," by John E. Lind, M.D., and "Auto-Plastic Bone Transplantation," by Vincent Anthony Lapenta, A.M., M.D. Besides those mentioned, there are a number of other articles which will appeal to diagnosticians and therapeuticians.

Transactions of the Tri-State Medical Association of the Carolinas and Virginia. Seventeenth Annual Session, Held at Charleston, S. C., February 17 and 18, 1915. Charlotte, N. C.: Observer Printing House. 1915. Illustrated.

Organization is the scaffold upon which success is built. The more highly organized a profession or nation the greater their success. These remarks apply with equal force to the medical profession. When working as isolated units, but little can be accomplished for the betterment either of the profession or mankind. It is this idea that Dr. Register in his inaugural address, "The Advantages of Medical Education," drives home with especial force. Step by step he shows the advantages to be derived from medical organization, the local society, the city and State societies, the national societies. He states in this address, and truthfully, that the only way the medical profession is to advance either as units or as a body is for the members of the profession to go to medical society meetings and report their observations and to enter into

the discussions and to print these observations both for the purpose of preservation as well as dissemination. The address is certainly of a high order of merit, and more than justifies the reason for the existence of medical societies. What one keeps to himself nobody else learns unless he falls upon it accidentally. The medical society makes this knowledge the property of the whole profession, to be incorporated into the mental equipment of each and every doctor if useful, or after sufficient testing and found wanting to be thrown into the medical ashpile. We congratulate Dr. Register upon the excellence of his address and the scholarly manner in which he has presented the advantages of medical societies.

The Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. December, 1915. Published Bi-Monthly. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Paper, $8 per annum.

This issue, as usual, is full of useful articles. Bone surgery, as in a number of the preceding volumes, occupies a large part of the number. Fracture, both old and new; joint surgery and handling of malignant growths of the bone receive especial attention. Besides a full discussion of these conditions, there are talks cicatrical fixation of ulnar nerve in its groove sequential to ancient fracture of olecranon process, release and transference of nerve to new site, resection of tip of olecranon, adeno-carcinoma of neck of the uterus, vaginal hysterectomy by Jacobson's method, undescended testicle, orchidopexy, carcinoma of maxillary antrum, etc. You are by this time acquainted with the scope of these clinics. If not, you should be. Each issue contains much you will find of practical value in your daily tasks.

Sexual Impotence. By Victor G. Vecki, M.D., Consulting Genito-Urinary Surgeon to the Mt. Zion Hospital, San Francisco. Fifth Edition, Enlarged. Philadelphia and London: W. B. Sanders Company. Baltimore: The Medical Standard Book Co. 1915. Cloth, $2.25 net.

No greater calamity can befall a man than to come to a sudden realization that he is impotent. Consequently, impotency should receive the most careful study and thought of the profession. Instead of being a tabooed subject, this affliction should be openly discussed at medical meetings and in textbooks, so that any additional light that can may be shed in helping to overcome the condition. With the loss of potency goes the loss of love, and many a family has been broken up because the husband has been unable to supply the sexual appetite of his wife. This is a deplorable condition; in fact, there is no more distressing and baleful affection within the realms of medicine. And do not for a minute think that impotency is a rarity, for those who have given it thoughtful consideration say it is of frequent occurrence. Their experience proves that the large towns harbor crowds of persons who are

afflicted with sexual infirmities which throw a gloom over their existence. These are not confined to any age or any stratum of society, the wealthy and the poor being afflicted alike. At the dawn and eventide of life man is dependent on woman, and especially in his heyday is she an absolute necessity. Anything which thwarts this desire makes man gloomy, incompetent and moody; therefore, a subject which is of so much importance to mankind should receive the most profound consideration. The race, the nation and family happiness is dependent upon potency. Without it all would soon cease to exist. What problem, then, is more real than the alleviation of these victims. It is with this idea that Dr. Victor G. Vecki has issued the fifth edition of his work on Sexual Impotence. In doing so he has performed a distinct service to mankind, and thereby causes the run of the profession to stop, look and listen to this the most woeful affliction that could befall man. It is a book every member of the profession should read, digest and think over, for by helping one of these unfortunates to overcome his disability a life-giving service has been performed.

A Text-Book of Physiology. For Medical Students and Physicians. By William H. Howell, Ph.D., M.D., Sc.D., LL.D., Professor of Physiology in the Johns Hopkins University, Baltimore. Sixth Edition, Thoroughly Revised. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Company. Cloth, $4.00 net. 1915.

With the progress of time, physiology becomes daily rather more than less intricate. Therefore it is an extremely difficult task to present the varying shifts of physiological thought. Nevertheless, we believe that for student purposes Howell has once more shown his versatility by presenting the subject plainly, succinctly and conservatively. It is the underlying or basic principles that most concern the student, and Howell has handled this side of the subject with the same nicety as heretofore. The changed thought in the physiology of nutrition has made it necessary for him to entirely recast his material on this phase of his subject. Even here the contents are put in such a clear manner and accurately reflect the latest views on the subject. Maintaining, as it does, the same high standard of excellence of its predecessors, it will continue to reign supreme in this particular field.

The American Illustrated Medical Dictionary. Dorland. Eighth Edition. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1915. Leather, $4.50. Thumb Index, $5 net.

The eighth edition of the American Illustrated Medical Dictionary, by W. A. Newman Dorland, A.M., M.D., F.A.C.S., professor of gynecology, Post-Graduate Medical School, Chicago; fellow of the American Academy of Medicine, has been thor-

oughly revised, so that it is now right up to the minute. When its predecessor appeared in 1913 it was the last word in medical interpretation, but since that date so many new terms have wormed their way into medicine that it was found necessary to revise the previous work. This volume contains a new and complete list of the terms used in medicine, surgery, dentistry, pharmacy, chemistry, nursing, veterinary science, biology, medical biography, etc., with the pronunciation, derivation and definition. It is impossible for a physician to get along without a dictionary. So it is up to him to decide which one meets his wants best. He will find this one better in this respect, and that one in another, but taking all in all, he will be more than pleased with Dorland's, and will not go wrong when purchasing it. It is attractively gotten up, of reasonable price, and contains, besides the material ordinarily found in dictionaries, much of an encyclopedia nature. It gives us great pleasure to again heartily endorse it and to recommend it to the kindest consideration of our readers.

International Clinics. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Vol. II. Twenty-fifth series. 1915. Philadelphia and London: J. B. Lippincott Co.

International Clinics, as a glance at the partial cataloguing of the contents will attest, affords an easy method of keeping abreast of the times. What more can one ask than the cerebro-spinal fluid in diagnosis, the diagnosis and treatment of arterio-sclerosis, chronic habitual constipation—a practical consideration of its causes, results, and its rational treatment by mechanical measures, a case of cancer of the pancreas in a boy of nine years of age, with notes on other reported cases of cancer in children, typhoid and the psychoses, a consideration of some painful conditions of the foot, some remarks on gastro-intestinal surgery. The present issue is particularly rich in well-selected and timely topics. One would, however, be disappointed if such were not the case with each succeeding number as one comes to look for more than the ordinary in the Clinics after becoming a steady reader.

An Epitomized Diagnosis of Gastro-Intestinal Diseases. Jersey City: Reed & Carnrick.

This booklet as completely and concisely as possible covers the subject of gastro-intestinal disorders. It is nothing more or less than its title suggests—an epitome. Nevertheless, when one is in a hurry to obtain a digest of a specific malady of the gastro-intestinal tract, he can do so with the least expenditure of energy and loss of time by consulting this monograph. It embraces concise statements concerning the stomach, X-ray diagnosis of gastro-intestinal disorders, pyloric stenosis, cancer of the stomach, atony of the stomach, appendicitis, typhoid fever, right-side abdominal pain, bacillary dysentery, peritonitis and a wealth of other useful information.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor.*

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BALTIMORE, APRIL, 1916

MINERAL OIL IN CONSTIPATION.

SIR A. LANE of England has popularized the use of mineral oil in constipation to such an extent that it has now to a large extent supplanted other methods of controlling this fault of the alimentary canal. In discussing the employment of liquid albolene in constipation and obstipation in *American Medicine*, A. C. Geyser, M.D., of New York, states no therapeutic agent should ever be administered to a patient unless that agent is in perfect harmony with the physiological functions of the organ to be affected. Constipation and obstipation is not a disease, but a symptom of a perverted physiological function. There is no normal time exhibited for the passage of food residue through the digestive tract. It may be within the limit of normal physiology for an individual to have a bowel movement but once every five or six days; it is equally possible for another individual to have such a movement twice every 24 hours. Until, and not until, retention produces symptoms of toxemia or discomfort by mechanical distention should artificial measures be taken to evacuate the bowels. According to the author, the most common cause of retention is inflammation of the colon with a more or less temporary abeyance of the mucus secreting function of the mucous membrane. This mucus mixes with and softens the fecal matter, and covers the lumen of the colon, thereby facilitating the onward passage of the alimentary contents and prevention of injury

to the mucous membrane. When the stool is dry, not formed and not coated with mucus, a substitute for this substance must be found. Liquid albolene is the substance par excellence that lends itself as a physiological substitute for mucus, according to Dr. Geyser. When properly prepared, it is tasteless and odorless, does not undergo putrefactive changes, is not absorbed by the system, does not irritate the lumen of the gut, mixes readily with the feces, lubricates and protects the mucous membrane—in short, does just what should be done by the normal mucus, and nothing more. An oil intended as a therapeutic agent must be of the mineral variety to prevent its being absorbed. Consequently, a mineral oil must only be administered with the idea of lubrication. It has no other physiological action, as it is not taken into the system. To render it more palatable and agreeable to the taste a small quantity of an essential oil may be mixed with it. The mixture has the added virtue of causing contraction of the hollow viscera of the digestive tract. The oil should be of not too low a specific gravity, as it will then pass through the digestive tube without being held by the feces; nor must it be of too high a specific gravity, as in this event it simply acts as a lubricant in spots. The Russian oil was almost entirely employed for this purpose, until the great European War. At that time it was thought that this oil was the only one fit for the purpose, but that has been found to be a mistaken idea, any American oil of sufficient specific gravity and freed of all foreign material answering the purpose just as efficaciously. The experience of Geyser with American oils is indeed gratifying, as some one or other of these preparations are being extensively employed in the combatting of constipation. Certainly in the overcoming of functional stasis no simpler or better agent has been introduced than liquid vaseline, but physicians must not place too much dependance upon any case being of a physiological character until he has exhausted all means of accurately determining whether the tardiness of emptying the bowel is due to a mechanical fault. If the constipation is a result of loss of physiological tone, then undoubtedly mineral oil judiciously administered will be of inestimable value.

Medical Items.

The following physicians were appointed during the past week by Governor Harrington as coroners to the various stations in Baltimore: Drs. James K. Insley, Otto M. Reinhardt, F. Edward Smith, Walter L. Denny, Albert D. Driscoll, William T. Riley, James G. Wiltshire, Henry L. Siuskey and John J. Morrissey, Jr.

Dr. Walter E. Dandy, for several years one of the assistant surgeons at Johns Hopkins Hospital, has been appointed resident surgeon of the hospital, to succeed Dr. Roy D. McClure, who recently resigned to become surgeon-in-chief at the new Henry Ford Hospital in Detroit, Mich. Dr. Dandy has made a special study of surgery at the Hopkins Hospital for nearly six years, and has had considerable experience in research work.

Two more members of the staff of the Johns Hopkins Hospital, Drs. Stewart Vernon Irwin, class of 1914, of Oakland, Cal., and Jerome Pierce Webster, class of 1913, of Plymouth, N. H., have resigned and will go to Germany to make a scientific examination of conditions prevailing at the great prison camps there. They will report to the American Red Cross headquarters at the American Embassy at Berlin. Drs. Irwin and Webster will have access to the immense prison camps, where hundreds of thousands of British, French and Belgian prisoners are confined.

The North Carolina Surgical Club visited the University of Maryland Hospital on March 2 and was present at special clinics held by Professors Randolph Winslow, Arthur M. Shipley and J. Mason Hundley, at which a number of important operations were performed, such as cholecystectomy, choledochotomy, hysterectomy and amputation of breast. Drs. Robert F. Bay and Fred Rankin also held clinics at the same time, but there was such an embarrassment of riches in clinical material that it was impossible for the visitors to see all that was offered them. Mr. Harry Warfield, manager of the hospital, served a delightful luncheon after the clinics. The visitors expressed themselves as being greatly pleased with their cordial reception and entertainment. They left in the evening for Pittsburgh, and will also visit Cleveland, Chicago and Cincinnati.

Arrangements are being completed for the commemoration of the twenty-fifth anniversary of Dr. Randolph Winslow as professor of surgery at the University of Maryland. The celebration will take the form of a dinner at the Hotel Belvedere on or about the 28th of April. The committee on arrangements includes Drs. William P. Stubbs, chairman; Arthur M. Shipley, William Tarun, G. Milton Linthicum, Alexius McGlannan, Fred W. Rankin and Elmer Newcomer.

The Sixth Annual Health Conference of the Medical and Chirurgical Faculty of Maryland, in co-operation with the Maryland State Federation of Women's Clubs, conducting the baby welfare movement, was held at Osler Hall, 1211 Cathedral street, March 6-11, inclusive. There were a number of interesting and instructive lectures given relating to child welfare. A feature of the celebration was the exhibit of hundreds of posters made for the Better Baby Poster Contest.

Dr. Charles A. Waters, formerly of Govans, Md., desires to announce that he has opened offices at 1100 N. Charles street, Baltimore, Md., equipped for radiographic and fluroscopic examinations and for extensive X-ray therapy. The equipment includes apparatus for uretral catherization and stereoscopic pyelography; for Pirie's method of serial gastro-intestinal radiography; for upright and prone gastro-intestinal fluroscopy, and for teleroentgenography of the heart. Consultation by appointment from 8-9 A. M. and 5-7 P. M. Telephone, Mt. Vernon 5856.

At the meeting of the Baltimore City Medical Society, Friday, March 3, 1916, Dr. John C. Hemmeter read a paper on "The Value of Duodenal Feeding in the Preparatory Period to Gastric Operation."

Dr. Harry J. Moss, New York city, who was recently appointed superintendent of the Hebrew Hospital, to succeed Dr. Mason R. Pratt, resigned, has taken up his new duties. He was formerly assistant superintendent of the Mount Sinai Hospital in New York.

BIRTHS.

To Roades Fayerweather, M.D., Johns Hopkins Medical School, '03, and Mrs. Fayerweather, of Roland Park, March 11, 1916, a daughter.

Recently, to Norbert Charles Nitsch, M.D., University of Maryland Medical School, '13, and Mrs. Nitsch, a son—Norbert Charles Nitsch, Jr.

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Our Ampules are an admirable adjunct to our line of soluble hypodermic tablets, and you know them.

MARRIAGES.

Frank Martin, M.D., University of Maryland Medical School, '86, professor of operative and clinical surgery in his alma mater, to Miss Elizabeth Prescott Bigelow of Boston, Mass., at Boston, March 1, 1916. After several weeks spent at Palm Beach, Fla., Dr. and Mrs. Martin will reside at 1000 Cathedral street.

Roy Donaldson McClure, M.D., Johns Hopkins Medical School, '08, of Baltimore, Md., to Miss Helen Keene Troxell of Walbrook, Md., at Walbrook, March 4, 1916. After a Northern journey, Dr. and Mrs. McClue will live in Detroit, Mich., where Dr. McClure is surgeon-in-chief of the Henry Ford Hospital.

Nell M. Pottenger, R. N., Johns Hopkins Hospital, Baltimore, class of 1912, to Mr. L. C. Maxwell of Liberty, Ind., October 18, 1915. Mr. and Mrs. Maxwell will reside in Liberty, Indiana.

Florence M. Anderson, R. N., St. Joseph's Hospital, Baltimore, class of 1915, to Mr. Jos. Mitchell, both of Baltimore, Md., at Baltimore, in December, 1915. They will live in Baltimore.

Elizabeth Rossiter, R. N., St. Joseph's Hospital, Baltimore, class of 1914, to Mr. John Holmes of Owen's Sound, Canada, at Toronto, Canada, in December, 1915. Mr. and Mrs. Holmes will live in Owen's Sound, Canada.

DEATHS.

Timothy Griffith, M.D., of Frostburg, Md., one of the leading physicians of Western Maryland, a former vice-president of the Medical and Chirurgical Faculty, died at his home March 2, 1916, aged 55 years.

George Lane Taneyhill, M.D., University of Maryland Medical School, '65; a Fellow of the American Medical Association; formerly president of the Baltimore City Medical Society; vice-president of the Obstetrical and Gynecological Society of Baltimore; assistant surgeon of the Eleventh Maryland Volunteer Infantry during the Civil War; major, Medical Corps, Sixth Infantry, Maryland National Guard (retired), formerly president of the National Association of United States Pension Examining Surgeons; one of the most beloved practitioners of Baltimore, died at his home, 1003 Madison avenue, Baltimore, from heart disease, March 2, 1916, aged 75 years.

J. McKendree Kemp, M.D., University of Maryland Medical School, '63, of Welcome, Md., surgeon in the Federal service during the Civil War and thereafter a practitioner of the Western Shore, Maryland, died in the Johns Hopkins Hospital February 18, 1916, from heart disease, following the amputation of the right leg, aged 70 years.

Elisa C. Etchison, M.D., University of Maryland Medical School, '74, of Gaithersburg, Md., one of Montgomery county's leading physicians, died in a hospital in Washington, D. C., February 5, 1916, aged 67 years.

William A. Marbury, M.D., University of Maryland Medical School, '01, of Sabillasville, Md., formerly demonstrator of histology and embryology in his alma mater, died in Baltimore December 13, 1915, from pulmonary tuberculosis, aged 37 years.

R. C. Buck, M.D., University of Maryland Medical School, '74, of Bristow, Va., died at his residence in that place February 1, 1916, aged 65 years. Dr. Buck was born in Warren county, Virginia, in 1851.

Rufus H. Smith, M.D., College of Physicians and Surgeons, '77, a retired practitioner and capitalist, who had resided in Seattle since 1899; for six years chief surgeon of the Great Northern and Columbia and Puget Sound railroads; a member of the Legislature from King county, and president of the Senate in 1903, died in the Seattle General Hospital February 12, 1916, aged 64 years.

Paul Rider, M.D., College of Physicians and Surgeons, '11; a Fellow of the American Medical Association and a practitioner of Wardensville, W. Va., died at the home of his wife's parents in Morgantown, W. Va., February 1, 1916, from myocarditis, aged 31 years.

James F. Hughes, M.D., University of Maryland Medical School, '60, surgeon in the Confederate service during the Civil War and thereafter a practitioner of Allegany county, Virginia, died at his home in Clifton Forge, Va., January 31, 1916, aged 81 years.

Jesse J. Hall, M.D., College of Physicians and Surgeons, Baltimore, '82, died at his residence in Morgantown, W. Va., from apoplexy, October 30, 1915.

James T. Jones, M.D., Washington University, School of Medicine, Baltimore, '70, of Jackson, Tenn., died at his home recently, after a brief illness, aged 69 years.

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CONTROLLING CANCER IN ENGLAND.

Portsmouth was the first municipality in England to undertake a public educational campaign for the control of cancer, and it would appear that the measures adopted in 1913 are already taking effect. The annual report of the Medical Officer of Health, Dr. A. Mearns Fraser, for the year 1914, which has just been received, states that there were only 197 deaths from cancer in Portsmouth last year, as compared with 230 in 1913. This decrease, which occurs in the face of an increase of population, is hailed with satisfaction by the Portsmouth sanitary authorities as justifying their efforts to reduce the cancer death rate by persuading persons who are attacked with this disease to avoid delay and to seek treatment before it is too late for more than palliative measures. Dr. Fraser reports that from statements made to him by local medical men the publication of circulars and newspaper articles by the Health Department has been instrumental in inducing a number of persons suffering from early operable cancer to secure treatment, the result of which, it is hoped, will be permanent.

When the educational measures were put in force two years ago the cancer death rate of the city had for a long period been increasing. Twenty years ago the average death rate from cancer in Portsmouth was 6.79 per 10,000 of the population, but in 1913 it had risen to 9.16 per 10,000. In that year the total number of deaths was only 34 less than were caused by tuberculosis. While admitting that the increase in the recorded cancer death rate might have been caused in part by improved methods of diagnosis, the Health Committee of the Portsmouth Town Council nevertheless believed that the present number of deaths was unnecessarily large, and they felt it incumbent to adopt whatever measures might lessen the ravages of the disease. The initiative came from Dr. Charles P. Childe, senior surgeon of the Royal Portsmouth Hospital, and a member of the Health Committee of the Town Council. As early as 1906 Dr. Childe, in his book, "The Control of the Scourge," had given to the public the benefit of his extended experience with cancer. At his suggestion the Portsmouth authorities, in 1913, began a campaign of public education under the official auspices of the Health Department. The methods adopted included the monthly publication in the local newspapers of articles regarding cancer and the printing and distribution of a Health Department circular on the subject. Arrangements were made for periodical lectures to midwives, nurses, and to those engaged in social work in Portsmouth. The Health Department further made provision for free microscopical examinations and reports on suspected cancerous growths in order to assist physicians in immediate diagnosis in the case of patients who were unable to pay for such laboratory service. The experience of the Portsmouth authorities had been that by far the majority of patients who presented themselves at hospitals suffering from cancer exhibited the disease in a stage too advanced to be cured. It was held that the reason for this delay in seeking advice was not, as a rule, because patients feared operation, but because they were ignorant that they were suffering from anything serious until they began to suffer pain. The fact that cancer at its onset is almost always painless should be widely realized in order that the public may learn the importance of other symp-

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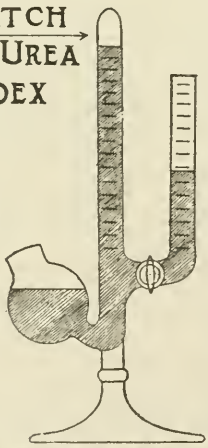
WATCH the UREA INDEX



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tions which will enable them to recognize the disease in the early stages, when it can nearly always be successfully removed by competent surgery.

THE CAMPAIGN AGAINST CANCER IN MISSOURI.

The most recent addition to the many agencies, national and local, now engaged in the warfare on cancer is the Department of Preventive Medicine of the University of Missouri. This department has just published in the University *Bulletin* a special article on the early diagnosis and treatment of cancer by Dr. F. A. Martin, instructor in pathology. The purpose of this bulletin is to call the attention of its readers in Missouri and elsewhere to the campaign for the education of the laity, which is being carried on by the American Society for the Control of Cancer, the American Medical Association and other national and State organizations, and to give a brief general survey of the cancer problem as a phase of preventive medicine.

The knowledge and skill of surgeons in the treatment of cancer has progressed, according to the *Bulletin*, almost to the limits of what is possible, and if the percentage of cures by this, the only method of treatment which offers reliable hope of cure, is to be increased, the patients themselves must co-operate by seeking earlier diagnosis and treatment. On examining the histories of a large number of cases, it has been found that the patients whom the surgeon failed to cure were those who came to him late in the disease, when the cancer had spread to such an extent that to remove all the cancer cells would have required an operation so great that in itself it would be sufficient to cause the death of the patient. On the other hand, it is found of another group of cases which sought treatment soon after the cancer was noticed that 100 per cent. were cured. To increase the percentage of cases treated early the University *Bulletin* urges that laymen learn the meaning of cancer and its first warnings, in order that they may go to the surgeon in time, when the cancer is still in the early stages, and the chance for cure is high.

Among the many facts already known about cancer, perhaps the most important is that the disease nearly always begins in some form of abnormal tissue. This abnormal tissue, which is often easily recognized, may have existed for only a few months, or it may have been present from early childhood without causing trouble, only to change into cancer in later life. To these bits of abnormal tissue, or groups of cells, has been given the name of "precancerous lesion." The *Bulletin* says that not all such conditions develop into true cancers, but most of them should be kept under careful observation by a competent medical advisor, and removed as soon as there is real danger of malignant disease. This is the only known method of preventing, as distinguished from curing, cancer, and the Missouri *Bulletin* describes carefully the various forms of precancerous lesions which should be regarded with suspicion. Among these are pigmented moles, cracks on the lip, blisters, scabs and similar persisting abnormal conditions of the skin. Probably only a very small proportion of these conditions become cancer, but when moles, for instance, are so located that they are subject to constant irritation, and when in later life they change in color and appearance, and begin to grow, it is time to have them promptly attended to.

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may often be readily traced to imperfect digestion of protein or fat, to a deficiency of total solids in the diet, to a lack of energy, or to a diet containing starchy substances. While this condition is not necessarily a serious one, a natural elimination with soft, smooth stools of a good character is much to be desired, and has no little bearing on the general health of the infant.

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Moles and warts should never be treated with caustic, but the whole lesion, together with its so-called roots, should be removed. When a burn on the tongue or lip from smoking does not heal within a few months it is a source of danger. Generaly speaking, the removal of precancerous lesions is a trivial operation requiring only local anesthesia.

After true cancer has developed it is still possible to cure a large percentage of cases, if the surgeon is given a fair chance while the disease is still local. All cases of cancer are local in the beginning, and may remain so for a few weeks to several months. It is during this period that surgical treatment offers the possibility of practically 100 per cent. of cures. Unfortunately for the patient, pain is so rare at this stage of the disease, and the conditions seem so trivial, that in a great number of cases the opportunity to be saved is forfeited by the delay. In cancer of the breast, for instance, the cases cured by the late operation amount to about 30 per cent., but by an early operation at least 80 per cent. are saved. If every woman who is not nursing would go to a surgeon within 24 hours after she finds a lump in her breast, 90 per cent. of the cases of cancer of the breast would be permanently cured.

Cancer of the tongue is perhaps the most malignant, and cures by the late operation are few in number. If a small ulcer appears on the tongue, consult a surgen at once. When such an ulcer is produced by a ragged tooth, consult a dentist first, and then if the ulcer does not heal within a short time after the cause has been removed, it is a surgeon's task.

In almost all the common forms cancer is connected with some kind of irritation. Gall-stones, for instance, should be removed, since it is established that from 4 to 14 per cent. of all cases are followed by cancer.

Cancer of the uterus gives early warning by a discharge of an unusual character at an unusual period, and of unusual duration. The removal of the uterus is not a dangerous operation, and if the disease is recognized at an early stage the life of the patient can be saved.

The *Bulletin* issues an emphatic warning against quacks and their bogus testimonials, pointing out that their method of deception lies mainly in the diagnosis. There are so many conditions closely resembling cancer that the average layman cannot distinguish among them, and it is behind such conditions which are not cancer, and which would tend to heal without treatment, that the "cancer specialists" take their stand and make their false claims.

The Department of Preventive Medicine will supply copies of this cancer bulletin, Medical Series No. 9, upon request to the University of Missouri, Columbia, Mo., as long as the supply lasts.

ENDOWMENT OF $500,000 TO AMERICAN COLLEGE OF SURGEONS.

The American College of Surgeons begins the new year with an announcement that it has secured from its Fellows an endowment fund of $500,000. This fund is to be held in perpetuity, the income only to be used to advance the purposes of the college. By

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this means lasting progress toward the purposes of the college is assured.

The college, which is not a teaching institution, but rather a society or a college in the original sense, now lists about 3400 Fellows in Canada and in the United States. Without precedent for swiftness of development it stands today a powerful factor both in the art and in the economics of surgery.

Primarily the college is concerned with the training of surgeons. But the significant fact in connection with the endowment just secured is that it has come from the surgeons themselves, inspired by a motive for better service to the patient. Ideals in the profession of medicine are living things. Probably no more convincing proof of this fact exists than the sacrifice which the surgeons of this continent have made willingly in order to raise this fund.

To begin with, these ideals are to find concrete expression along the following lines of activity:

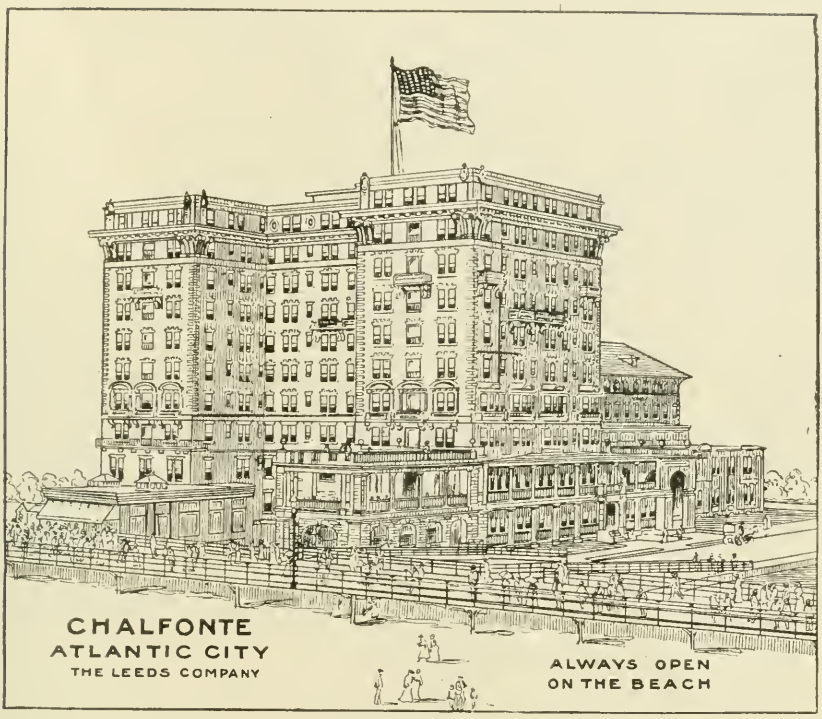
1. Since the whole problem of the training of specialists for the practice of surgery is the primary purpose of the college, the Regents propose at an early date to present a clear conception of the college to the undergraduate medical students of this continent. The Regents, further, will ask each senior student of this group who has in mind to specialize in general surgery or any branch of surgery to register with the college. As these students, then, serve later as internes and as surgical assistants, they will be requested to report these facts to the college. The college, in turn, will systematically seek information as to the ability and character of such men, and the information thus obtained becomes the basis of admission to Fellowship in the college. In addition to this procedure, the Regents will insist upon the proper keeping of case histories, and they will endeavor to stimulate in these men in training right ideals of medical practice. In this program they ask the active co-operation of the faculties of the medical schools and of all practitioners of medicine.

2. Inasmuch as proper training in surgery is inseparably involved with the conduct and efficiency of hospitals, the college will seek accurate data on all matters which relate to hospitals. From time to time it will publish studies upon hospital problems, the purpose being always to be helpful to the hospitals. These publications, further, will inform recent medical graduates as to where they may seek adequate general or special training in surgery. To be concrete, the college will deal with such problems as (a) the proper equipment for medical diagnosis, *e. g.*, well-equipped laboratories for chemical, pathological and X-ray work; (b) the proper forms for case histories and the facilities for keeping these records; (c) the management and the curricula of the nurses training schools; (d) the specialization essential in any well-organized hospital.

3. The college will ask the faculties of medical schools to consider the advisability of conferring a supplementary degree of proficiency in general surgery and in the various specialties of surgery.

4. The college will issue readable monographs, educational in nature to the press, to the general public, to hospital trustees, and to the profession of medicine upon subjects of medical procedure and the whole meaning of fitness to practice surgery.

The entire impetus of the college springs from within its own



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membership. Necessarily that impetus implies reform. But there is a vast difference between reform preached at men and reform innate in the hearts of men which finds expression at their own initiative. Whatever impetus the college possesses, it originates among the surgeons themselves. It is not an extraneous force or an "uplift" movement. But rather, out of the widely divergent views on many subjects among the Fellows, the aims of the college rise as those time-tried aspirations which are inherently the basis of all that is valuable in the vocation of surgery. The purposes of the college are concerned directly with matters of character and of training, with the betterment of hospitals and of the teaching facilities of medical schools, with laws which relate to medical practice and privilege, and with an unselfish protection of the public from incompetent service; in a word, they embody those ideals which have stood the test of centuries. Upon these the Fellows are united. These are the ideals which each Fellow, single-handed, has endeavored to foster, and the expression of them to-day through the college comes as a sort of mass-consciousness of the whole body of Fellows. The splendid fact is that the Fellows have grasped in an instant the meaning of the college by a process of fusion, and they have gladly made sacrifices for its success.

As one comes into wide acquaintance with the Fellows of the college and catches some fair notion of their earnestness, he sees the future of the organization not by means of logic. There is something more subtle and potent than argument. A determined optimism carries a momentum of its own. Without a logical process it seeks concrete expression, and, more than this, it really recreates circumstances through all shifts of weather or play of incident with a certainty not excelled by an utterly rational course. The Fellows of the college, in their widely-scattered districts, fuse their consciousness of the organization with a splendid hope in their hearts to advance all that is important and valuable in the profession. This very attitude of mind is the first promise for the future of the college. It is a promise that admits of no defeat. It is a pledge of loyalty to medical patriotism which means loyalty to the public welfare exercised through intellectual sincerity and scientific accuracy. It means a safeguard to the public, for it indicates where honest and adequate surgery may be found.

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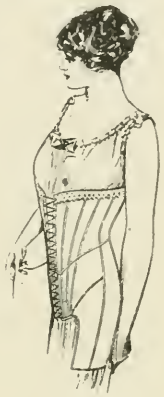

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

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The Elimination of Opium's Untoward Phenomena.

WERE it not for its several disagreeable features which are sufficiently weighty to make one hesitate before employing it, opium, of course, would be the ideal analgesic. Unfortunately, however, along with its analgesic effects, opium exerts those well-known phenomena which tend to limit its usefulness as a pain-relieving agent.

But with the discovery of processes by which it is possible to eliminate the convulsive and narcotic principles of the drug, PAPINE (Battle) became possible, and with a wider therapeutic application than opium.

In the manufacture of PAPINE the several objectionable qualities of opium have been eliminated, the finished product representing the analgesic and sedative properties only of this valuable drug.

In view of this, the superiority of PAPINE over opium and its alkaloids cannot be denied, for, although offering to the patient the positive analgesic properties of opium, it does not at the same time bind up his bowels or subject him to its other disagreeable effects. The utmost care is taken in the manufacture of PAPINE, and it is fully believed that it offers every possible advantage over opium.

The Test of a Tonic.

THE field and function of a systemic tonic is generally understood and appreciated by both physician and patient. To stimulate, whip or goad the vital processes is not to "tone," but, on the contrary, to ultimately depress. A real tonic is not a mere "pick-me-up," but some agent that adds genuine strength, force and vigor to the organism. The genuine tonic is a builder or reconstructor of both blood and tissue. Any agent which will increase the power of the blood to carry and distribute the life-

giving oxygen is a tonic in the best and truest sense of the word. Iron in some form is an ideal tonic, as it builds up the vital red cells of the blood and the hemoglobin, which is their essential oxygen-carrying element. Of all forms of iron, none is quite as generally acceptable and readily tolerable and assimilable as Pepto-Mangan (Gude). It creates appetite, tones up the absorbents, builds the blood, and thus is a real tonic and reconstructive of high order. It is especially desirable because of its freedom from irritant properties, and because it never causes a constipated habit.

The Pneumonia Convalescent.

WHILE the course and progress of acute lobar pneumonia is short, sharp and decisive, the impression made upon the general vitality is often profound, and apparently out of proportion to the duration of the disease. Even the robust, sthenic patient is likely to emerge from the defervescent period with an embarrassed heart and general prostration. In such cases the convalescent should be closely watched and the heart and general vitality should be strengthened and supported, and this is especially true as applied to the patient who was more or less devitalized before the invasion of the disease. For the purpose indicated, strychnia is a veritable prop upon which the embarrassed heart and circulation can lean for strength and support. As a general revitalizing agent is also needed at this time, it is an excellent plan to order Pepto-Mangan (Gude), to which should be added the appropriate dose of strychnia, according to age, condition and indications. As a general tonic and bracer to the circulation, nervous system and the organism generally, this combination cannot be surpassed.

The Reasons

why Gray's Glycerine Tonic Comp. should be employed in la grippe are numerous and strong. First of all, this remedy has proved its unique value in every epidemic that has occurred in this country. It fulfills pleasantly, effectively, scientifically—the ever present need for supporting tonic medication: it fortifies the system and enables the patient to withstand the ravages of the disease. One other exclusive feature of Gray's Glycerine Tonic Comp. is that it has a universally acknowledged specific influence upon the respiratory and nervous symptoms of la grippe—it palliates these symptoms —always—without the necessity of disturbing the stomach, depressing the heart and befogging the mental powers, with cough syrups, antipyretics and narcotics. It is a well-proven fact that if Gray's Glycerine Tonic Comp. is employed in la grippe there is no necessity of administering the usually employed large doses of analgesics and antipyretics; moreover, the danger of exhausting sequelæ is reduced to a minimum or entirely obviated. In short, Gray's Glycerine Tonic Comp. not only simplifies the treatment of la grippe, but robs it of most of its distressing features and dangerous complications. As a supporting reconstructive agent in convalescence from influenza no remedy acts so effectively as Gray's Glycerine Tonic Comp. It enables the patient to eat, digest and assimilate food, imparts vitality to the nervous system, restores constitutional vigor so that the system is fortified against the occurrence of complications and sequelæ.

The above statements are based upon the recorded experience of numbers of physicians who invariably employ Gray's Glycerine Tonic Comp. as a routine remedy in epidemic influenza or la grippe.

Doses: Adults two teaspoonfuls to a tablespoonful in water before meals (or after meals when preferred) and at night on retiring; children in proportion.

"In Particular Cases."

THERAPEUTIC efficiency in the use of the bromides is often as dependent on the avoidance of untoward effects as on the attainment of maximum physiologic activity. For this reason Peacock's Bromides offer the most satisfactory bromide therapy, for not only does this happy combination of carefully selected bromide salts insure all the benefits of the most active bromide preparation, but it does so with the great advantage that gastric disturbance and all tendencies to bromism are reduced to a minimum. This is why in "particular cases" so many physicians are in the habit of insisting on the use of Peacock's Bromides.

When the Stomach Is Tired or Lazy.

THE artificial digestives, such as pepsin, pancreative papain, etc., have their place in modern therapy, but they should always be used with care and common sense. How often do we encounter patients who are continually dosing themselves with pepsin or some one of the artificial digestives after each meal? Ninety-nine times out of a hundred this is unwise and a positive harm. Instead, the process of digestion should be encouraged—the stomach urged to do its own work—for any remedy that will specifically stimulate these functions to nearer

normal action will produce permanent benefits that can never come from pepsin. Seng is such a remedy with a well-defined secernent action on the glands and mucous membranes of the stomach that enables it to restore and increase the functional activity of an organ that in the great majority of instances is only over-tired or indolent.

THE increasing knowledge of endamebas and their relation to infections and other pathological conditions calls for an extension of ipecac therapy. The alkaloids of ipecac are specific for the endamebas and quickly destroy all motile forms, but if given by mouth they cause great nausea. The hypodermatic injection of emetine is efficient but time-consuming, frequently painful and expensive.

Alcresta Tablets of Ipecac, Lilly, have made it possible to administer the ipecac alkaloids by mouth in massive doses without causing vomiting or nausea. These tablets are uncoated and disintegrating, but do not liberate the alkaloids until the compound reaches the alkaline intestinal juices. Thus vomiting and nausea are avoided. Both physicians and dentists are using these tablets with much success in dysentery and pyorrhea, and also in many affections that are known to have their source in local foci of infection.

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The Prophylactic Importance of Effective Correction of Liver Disorders.

IN connection with the modern tendency of medical practice to anticipate many human ills by instituting prophylactic treatment as soon as their possible occurrence is suspected—or, to perpetrate a bull, by "treating them before they begin"—it is especially interesting to note the growing recognition of the part played by the liver in the causation of many common affections. That the liver is an all-important factor in the etiology of no small proportion of the metabolic disturbances, intestinal derangements and so-called auto-toxic disorders, is becoming more and more apparent as the physiologic functions of this great organ are given more careful attention and study. Moreover, as facts unfold, it is very evident not only that the importance of the liver has not been fully appreciated, but that prophylactic treatment to accomplish, with any degree of efficiency, the prevention of the ills referred to, must be directed primarily and principally to restoring and promoting the activity of the hepatic functions.

For many years the principal agents for attemping to restore the functional activity of the liver and regulate the portal circulation have been the hydragogue cathartics. In certain conditions these have been serviceable and more or less effective, but in many others they have proven valueless and even harmful, because of the exhaustion and depression resulting from the incidental catharsis.

In any comprehisive or effective scheme of prophylaxis of the affections due to insufficient or perverted hepatic activity the great desideratum is, therefore, to correct the liver condition without producing catharsis or purgation. The remedies that are able to meet this demand are very limited. In Chionia, however, the medical profession have a preparation of Chionanthus Virginica that can be relied upon to exert a prompt stimulating and corrective effect on the liver without setting up a severe and drastic action of the bowels. The possibilities of such a product must at once be apparent. Certainly clinical experience has demonstrated its therapeutic utility, for under its use the functions of the liver are promptly restored to the normal, with all that this essentially means on metabolic processes in general, the elimination of toxic wastes and the regulation of the bowels. The use of Chionia, therefore, through its potent influence on the liver, affords a dependable means of preventing many ills that all too often lead to serious and prolonged invalidism.

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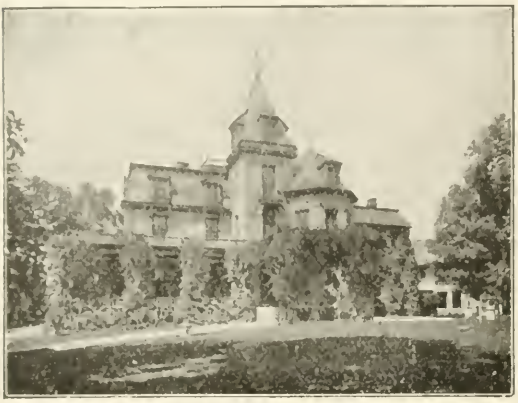

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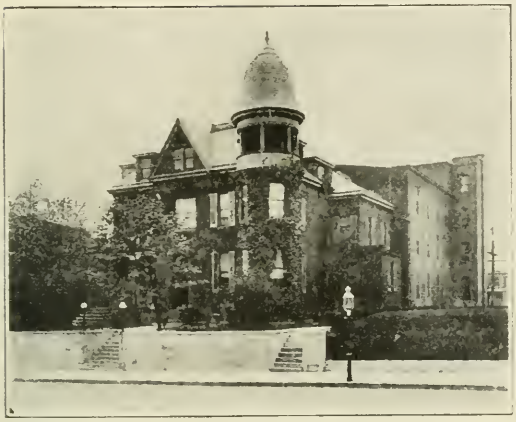

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